Medicaid Disability Application





Objectives

- Understand how to accurately complete a Medicaid Disability Application
- Effectively assist clients with filling out an application
- Reduce delays in application processing
- Reduce amount of incomplete/inaccurate applications



Who Determines Disability

- Blindness or disability is determined by:
 - Social Security Administration (SSA)
 - Receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
 - The State Disability Contractor
 - Action Review Group (ARG)
- Same criteria is used by both
 - Called the Sequential Evaluation
 - ARG may use a limited evaluation for adults only



ARG Determination

- Full Disability Criteria:
 - Inability to engage in any substantial gainful activity
 - Must be physically or mental impaired
 - Expected result in death or which has lasted or expected to last for a continuous period of not less than 12 months
- Limited Disability Criteria:
- Substantial Gainful Activity (SGA)
 - Does not need to perform on a full time basis, could be performed on a part time basis
 - Individuals who have worked in recent years
 - Usually worked 5 out of the last 10 years



Disability Application

- The Medical Assistance Application must be received at an eligibility site
- Determine if the applicant needs to complete the Medical Disability Application
 - If the applicant is age 65 or older, the disability application is not required
 - If the applicant is receiving SSI or SSDI the disability application is not required



Disability Application

 The Medical Disability Application and forms can be located at www.Colorado.gov/hcpf

- Click on Applications
- Applications and Forms are both in English and Spanish
 - -Disability Application
 - -Release Form



MEDICAID DISABILITY APPLICATION INSTRUCTIONS

Please read all information before you complete of this form.

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and then your county technician will help you finish it.

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to decide if you meet the disability criteria for Medicaid benefits in Colorado. Please remember that being found disabled does not guarantee you will receive Medicaid. You must meet all of the eligibility criteria, which includes disability, These include1) disability 2) financial and 3) level of care to receive Medicaid.

- Please fill out as much of this form as possible.
- **Do not leave answers blank.** If you do not know the answer, or the answer is "none" or "does not apply," please write: "don't know" or "none" or "does not apply."
- Each address should include a Zip Code. Each phone number should include an Area Code. You must provide complete information for each doctor you identify on this form. Failure to provide complete information may result in those medical records not being used to make a decision on your case.
- Do not ask a doctor or hospital to complete this form. But, you may get help from a friend, counselor, case manager, County Medicaid technician, or family member.
- Be sure to explain an answer if the question asks for detail or if you want to give additional information.
- If you need more space or want to tell us more about an answer, please use the "REMARKS" in Section 8 on page 10. Show the number of the question being answered.
- You may send copies of any medical records you have with this application.

Question C: An address where the client can be contacted <u>MUST</u> be provided

- Address needs to be a location where mail delivery can be guaranteed
- The address can be that of the person listed under Question "E"
- "Homeless" is not acceptable. A general delivery address can be given

MEDICAID DISABILITY	County					
APPLICATION	Date of Ap	Date of Application				
Start Here	·					
Section 1 – Info	ormation About The Dis	sabled Person(s)				
A. Name (First, Middle Initial,	Last) B. Social	Security Number				
C. Address (Street, City, Sta	ite, and Zip Code)					
D. Daytime Telephone Numb						
	number where we can le _ This is □ Your number	ave a message for you.) \ □ Message □ None				
	_ This is □ Your number	□ Message □ None tact (other than your doctor)				
() E. Give the name of a friend or	_ This is □ Your number r relative that we can con ditions and can help you v	■ Message □ None tact (other than your doctor) with your application.				
E. Give the name of a friend or who knows about your cond Name Mailing Address (Number,	_ This is □ Your number r relative that we can con ditions and can help you v Relationship _ Street, Apt. No. [if any],	Message □ None tact (other than your doctor) with your application. P.O. Box, or Rural Route)				
() E. Give the name of a friend or who knows about your cond Name Mailing Address (Number,	_ This is □ Your number r relative that we can con ditions and can help you v Relationship _	Message □ None tact (other than your doctor) with your application. P.O. Box, or Rural Route)				
() E. Give the name of a friend or who knows about your cond Name Mailing Address (Number,	_ This is □ Your number r relative that we can con ditions and can help you verified. Relationship _ Street, Apt. No. [if any], tate Zip P shoes? Feet	Message □ None tact (other than your doctor) with your application. P.O. Box, or Rural Route)				

Date of application is essential to protect the client's rights and also to protect the eligibility site when processing is taking too long.

Please list the date that the Disability application was received by the eligibility site

Question B:

SSN Must be provided

- If undocumented, state so in this area
- If the applicant does not have an SSN, contact SSA to help the client obtain one

Questions I, J, and K:

•Important to determine the applicant's ability to work or learn new job skills

	If "No," what	eak English? t languages can	you speak? _		ntost who aposks	
>	English and				ntact who speaks person as in "D"	
	Name			Relationship		
	Mailing Add	ress(Number, S	Street, Apt. No	. [if any], P.O. E	Box, or Rural Route)	
	City	State	Zip	()_ Phone		
J. K.	Can you rea Can you writ	nd English? te more than you	ur name in En	glish?	es □ No es □ No	
	S	Section 2 – Your	Conditions	and How They	Affect You	
Α.	What are yo	ur conditions tha	at limit your ab	ility to work?		
			vour obility to	work?		
B.	How do you	r conditions limit	your ability to			
В.	How do you	r conditions limit	your ability to			
		r conditions limit] Yes □ No	
 C.	Do your con	ditions cause yo			∃Yes □ No	
 C. D.	Do your con When did your first bother your when did you	ditions cause yo	u pain or othe]Yes □ No	
 C. D.	Do your con When did your first bother you when did you because of your con	ditions cause your conditions you? ou become unably your conditions?	u pain or othe	er symptoms? [Yes No	

Section 2 questions:

The alleged impairment(s) must be specific

- •General complaints such as: "my back hurts" or "I have stomach pains." is not appropriate
- Must be medically diagnosed impairments that prevent working

All of these workrelated questions are needed to determine if the person has any skills to do other types of work

Question K:

•This is needed to check the applicant's federal disability status, which mandates their Medicaid eligibility

(G. Did you work at any time after the date your conditions first bothered you? ☐ Yes ☐ No								
ŀ	H. If "Yes," did your conditions cause you to: (check all that apply) Work fewer hours? (explain below) Change your job duties? (explain below) Make any job-related changes such as your attendance, help needed, or employers? (explain below)								
I	. Are you working now? ☐ Yes ☐ No								
	If "No," when did you stop working?								
J	J. Why did you stop working?								
ŀ //	Have you ever applied for Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)? ☐ Yes ☐ No								
//	If "Yes," on what date did you file the most recent application?								
	At which Social Security Office did you apply?								
	Was your Social Security claim: ☐ Allowed ☐ Denied ☐ Still pending								
	Section 3 – Information About Your Work								

A. List the kinds of jobs that you had during last 15 years that you worked.

Job Title (see example)	Type of Business	Wo	ates orked th/year)	Hours Per Day	Days Per Week	Rate of Pay (Per hour, day, week, month, or year)		
Cook	Restaurant	9/99	10/02	8	5	\$ 7.00	hour	
						\$		
						\$		
						\$		
						\$		

Section 3 Question A:

- •Needed to determine if the applicant has the ability to return to any of their prior work or if they have skills to do other types of work
- •Having this minimum amount of information allows for a determination to be made if the other job forms are not returned

Questions B thru J:

- Needed to determine the applicant's ability to perform their past work as they described
- Establishes how work is performed in the national economy, or if the application has the ability to do other types of work

B. Which job did you do the longest?									
C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" in Section 8.)									
D. In this job, did you: Use machines, tools, or equipment? Use technical knowledge or skills? Do any writing, complete reports, or perform duties like this? □ Yes No Yes No									
E. In this job, how many total hours each day did you do each of the following: Walk Kneel (bend legs to rest on knees) Stand Crouch (bend legs and back down and forward) Sit Handle, grab, or grasp big objects Climb Crawl (move on hands and knees) Stoop (bend down and forward at and forward at Handle small objects, write, or type waist)									
F. Lifting and carrying (Explain what you lifted, how far you carried)	ed it, and ho	w often yo	ou did this.)						
G. Check the heaviest weight lifted: ☐ Less than 10 pounds ☐ 10 pounds ☐ 50 pounds ☐ 100 pounds	or more	☐ 20 pc							
H. Check the weight frequently lifted: (Frequently means from 1/3 to 2/3 of the workday.) □ Less than 10 pounds □ 10 pounds □ 20 pounds □ 50 pounds □ 100 pounds or more □ Other									
I. Did you supervise other people in this job? ☐ Yes ☐ No If "No," go to Section 4; If "Yes," complete the following. How many people did you supervise? What part of your time was spent supervising people? ☐ hours Did you hire and fire employees? ☐ Yes ☐ No									
Did you hire and fire employees? ☐ Yes ☐ No J. Were you a lead worker? ☐ Yes ☐ No									

or mental problems th			☐ Yes ions, go to Section 5	□ No
List other names you maiden or married name		medical ı	records, including yo	our
	is who may have	medical	records or other	
Tell	Information abo			
	Information abo	ut your o	onditions.	Use an e:
D. List each doctor/clinic, sheet, if needed. Inclu	Information abo	ut your o	onditions.	
D. List each doctor/clinic, sheet, if needed. Inclu	Information abo	ut your o	nal you have used. I	

Section 4 - Information About Your Medical Records

Question D:

The name, address, and phone number of all doctors the applicant has seen in the last two years is essential.

• Not listing a provider may result in a denial for insufficient evidence

Street Address	Date First Seen		
City	Date Last Seen		
Phone ()	Next Appointment		
Reason(s) for Visits			,
What treatment was	received?		
vvnat treatment was			
vvnat treatment was			
vvnat treatment was			
Name			Date First Seen
Name Street Address	Stato	7in	
Name Street Address	State	Zip	Date First Seen Date Last Seen
Name Street Address City Phone	State	Zip	
Name Street Address City Phone		Zip	Date Last Seen
Name Street Address City Phone		Zip	Date Last Seen
Name Street Address City Phone		Zip	Date Last Seen

Continued

E. List each hospital you have used. Include your next appointment. Name Street Address City State Zip **Phone** Type of Visits Date In Date Out □ Inpatient Stays (stayed at least overnight) Date of First Visit Date of Last Visit □ Outpatient Visits (sent home same day) Date □ Emergency Room Visits Name Street Address City State Zip Phone Type of Visits Date In Date Out □ Inpatient Stays (stayed at least overnight) Date of First Visit Date of Last Visit □ Outpatient Visits (sent home same day) Date □ Emergency Room Visits If you need more space, use "Remarks" in Section 8.

Question E:

The name, address, and phone number of all hospitals the applicant has used in the last two years is essential.

 Not listing a hospital may result in a denial for insufficient evidence

Section 5

This information may evaluate impairments that the applicant may not have stated.

•Can lead to allowances for impairments that the applicant did not know were disabling

Section 5 - Tests

Have you had any medical tests for your conditions? ☐ Yes ☐ No (If "Yes," complete the information below.)

Kind of Test	When was test done? (month/day/ year)	Where was test done? (Name of facility)	Who sent you for this test?
EKG (heart test)			
Treadmill (exercise test)			
Biopsy – Name of body part			
Hearing Test			
Vision Test			
IQ Test			
EEG (brain wave test)			
HIV Test			
Blood Test (not HIV)			
Breathing Test			
X-Ray - Name of body part			
MRI/CT Scan – Name of body part			
Other- Name of test and on what body part			

If you have had other tests, list them in "Remarks" in Section 8.

Section 7 Questions

- Information may seem strange to request for a medical disability determination, but it **MUST** be included
- It is used to determine what types of other work, if any, the applicant might be able to do

Section 6 - Medications

Do you currently take any **medications** for your conditions? ☐ Yes ☐ No If "Yes," please tell us the following information:

(Look at your medicine bottles, if necessary.)

Name of Medicine	If prescribed, give name of doctor	Reason for Medicine	Side effects from the Medicine

Section 7 - Education/Training Information

A. Check the highest grade of school completed.

Approximate date completed: _

Grac	de so	cho	ol:								Cc	lle	ge:	
0 1	2	3	4	5	6	7	8	9	1011	12 GED	1	2	3	4 or more

B. Did you attend special education classes? ☐ Yes ☐ No *If "No," go to part C.* If "Yes," complete the following information:

Address ______(Number, Street, Apt. No. [if any], P.O. Box, or Rural Route)

	City		State	Zip	-
Date Attended		to		·	_
Type of Program					

Section 6 **Questions:**

Answers can reveal additional impairments that need to be evaluated

Section 8 - Remarks Use this section for any additional information you did not share in an earlier parts of this form. When you have completed this section (or if you don't have anything to add), go to the next page and complete the signature block.

· · · ·				
knowledge. I understand that I a Policy and Financing and its necessary contacts to verify any	m that everything is true to the best of my am giving the Department of Health Care designees the authority to make the statements made on this application and tion necessary to determine medical			
knowledge. I understand that I a Policy and Financing and its necessary contacts to verify any to request all records/informa disability eligibility. I understand any benefits will be paid to me or	am giving the Department of Health Care designees the authority to make the statements made on this application and tion necessary to determine medical that this application does not guarantee on my behalf.			
knowledge. I understand that I a Policy and Financing and its necessary contacts to verify any to request all records/informa disability eligibility. I understand	am giving the Department of Health Care designees the authority to make the statements made on this application and tion necessary to determine medical that this application does not guarantee on my behalf.			
knowledge. I understand that I a Policy and Financing and its necessary contacts to verify any to request all records/informa disability eligibility. I understand any benefits will be paid to me or Signature of claimant or person filin behalf (parent, guardian) Witnesses are required ONLY if this above. If signed by an (X) mark, two	am giving the Department of Health Care designees the authority to make the statements made on this application and tion necessary to determine medical that this application does not guarantee on my behalf. g on claimant's Date (Month, day, year) statement has been signed by an (X) mark witnesses to the signing who know the			
knowledge. I understand that I a Policy and Financing and its necessary contacts to verify any to request all records/informa disability eligibility. I understand any benefits will be paid to me or Signature of claimant or person filin behalf (parent, guardian) Witnesses are required ONLY if this above. If signed by an (X) mark, two person making the statement must s	am giving the Department of Health Care designees the authority to make the statements made on this application and tion necessary to determine medical that this application does not guarantee on my behalf. The provided Health Care and the statement has been signed by an (X) mark of witnesses to the signing who know the ign below, giving their full addresses.			
knowledge. I understand that I a Policy and Financing and its necessary contacts to verify any to request all records/informa disability eligibility. I understand any benefits will be paid to me or Signature of claimant or person filin behalf (parent, guardian) Witnesses are required ONLY if this above. If signed by an (X) mark, two	am giving the Department of Health Care designees the authority to make the statements made on this application and tion necessary to determine medical that this application does not guarantee on my behalf. g on claimant's Date (Month, day, year) statement has been signed by an (X) mark witnesses to the signing who know the			

County Technician's Comments:		
Technician's Printed Name	Technician's Signature	

Date

Email address

Supervisor's Telephone Number

County Department

Telephone Number

Supervisor's Name

Eligibility Staff should make comments here

This information must be filled out by the eligibility site.
The application will not be processed without this information. Please do not forward the application to the state disability contractor without completing this portion

•This form must be completed for a personal representative to receive information about the applicant's disability determination

- •This form allows the applicant to appoint someone to act on their behalf
- •This form does not allow the representative to sign the release of medical records forms

Signature: __

If you want or need someone to help you with your claim, please complete this form

DESIGNATION OF PERSONAL REPRESENTATIVE

For the Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more

/	persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time. See the Department's Privacy Policy and Procedures on <i>Personal Representatives</i> , pursuant to 45 C.F.R. 164.502(g).				
	Date:				
	DESIGNATION OF PERSONAL REPRESENTATIVE				
	(print your name) hereby name the following person to act is my authorized personal representative with respect to decisions involving the use and/or sharing of protected health information that pertains to me.				
	Name of Personal Representative	Relationship to Applicant			
	Personal Representative Social Security #	Personal Representative Phone			
	LIMITS TO THE AMOUNT OF INFORMATION	PROVIDED – Please check one			
	The person named above is to be with respect to my protected hea	e given all of the privileges that would be given to me lth information.			
	The person named above is actired the following function(s):	ng as my designated personal representative ONLY for			
	State ID number: A	pplicant signature:			
	Date of birth: Se	ocial Security # :			
	REVOCATION SECTION				
	returning it to the Department's Privacy Officer a	at any time by signing the revocation section below and at the above address. I understand that any revocation can only my protected health information and cannot cancel actions in was in effect.			
I no longer want this person to act as my personal representative.					

Date:

Do not sign unless revoking personal representative

Instructions for form on next page

• One form for **EVERY** medical source listed on the application

And

• Sign three additional forms

HOW TO COMPLETE MEDICAL RELEASE FROMS

- Only your signature is needed. Sign your full name in the space marked "INDIVIDUAL authorizing disclosure."
- Sign each release form.
- Leave all other areas blank. **Do not date** the release forms.
- You need to sign **one (1) release for every doctor or hospital** you have listed on this form. You also need to sign **three (3) additional** release forms for any new or discovered medical sources.
- If you do not have enough release forms, please contact your county technician to get more.

REQUEST ENOUGH RELEASE FORMS

Count the number of doctors, hospitals, and medical sources you listed in the application and write that number on this line.	A.	
The number of extra release forms you need is 3	В.	_+ 3
TOTAL: A + B = C. Add the number you listed in A and the number listed in B. That tells you the total number of release forms you need.	C.	
16 th	- 41	

If the number of release forms listed in "C" is more than you have in the application packet, call your county worker and ask them to send you more.

Applicant fills out everything except gray portion

Sign Only!

fill out any other information.

Do Not date or

WHOSE Records to be Disclosed					
NAME First	Middle	Last			
SSN	Birthday (mm/	dd/yyyy)			
ARG USE ONLY NUMBER HOLDER (if other than above) NAME					

AUTHORIZATION TO DISCLOSE INFORMATION TO ARBOR E&T, LLC ACTION REVIEW GROUP (ARG)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange): OF WHAT All my medical records: also education records and other information related to my ability to perform tasks. This includes specific permission to release:

- All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to: -Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501) -Drug abuse, alcoholism, or other substance abuse -Sickle cell anemia -Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases -Gene-related impairments (including genetic test
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and
- speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluation.
- Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment. and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by ARG
- Employers
- Others who may know about my condition
- (family, neighbors, friends, public officials)

TO WHOM The State contractor authorized to process my case including contract copy services, and doctors or other professionals

PURPOSE

Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

THIS BOX TO BE COMPLETED BY ARG (as needed). Additional information to identify

the subject (e.g., other names used), the specific source, or the material to be disclosed.

Determining whether I am capable of managing benefits ONLY (check only if applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- I may write to ARG and my sources to revoke this authorization at any time (see page 2 for details).

38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

- ARG will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed. have read both pages of this form and agree to the disclosures above from the types

rnaro roda both pagos or tino form and agr			o nom the types of sources in	
		ent/guardian sign		
Date Signed	Street Address			
Phone Number	City	State		Zip
				l
WITNESS I know the person signing this form or am satisfied of this p		son's identity:	IF needed, second witness si above SIGN	gn here (e.g., if signed with "X"
SIGN ►			o.o.v	
Phone Number (or Address)	Phor	ne Number (or Ad	dress)	

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and othe

information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332;

Applicant must sign this and any additional forms

If the applicant is unable to sign:

•A Durable Power of Attorney stating that someone else has the power to request medical records must be attached to the application.

 A standard Power of Attorney is not sufficient

EXPLANATION OF FORM MEDICAL RELEASE 2 "AUTHORIZATION TO DISCLOSE INFORMATION TO ARBOR E&T, LLC ACTION REVIEW GROUP (ARG)"

We need your written authorization to help get the information required to process your application for benefits, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a Form ARG Release 2. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source, and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to ARG. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; ARG can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by ARG to decide your claim.

It is ARG's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. ARG makes every reasonable effort to ensure that the information in the ARG Release 2 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by ARG is protected by the Privacy Act of 1974. Under a Business Associates Agreement with the State of Colorado (HCPF), your private health information is protected and will not be used for any purpose other than to make a medical disability determination. Your personal health information remains protected under the health information privacy provisions of 45 CFR 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). After a medical determination is made and the necessary waiting period for appeal purposes has passed, all medical information is sent to the county where you applied. Once the medical information is returned to the county, it will be destroyed in order to protect your personal health information.

ARG is authorized to collect the information on form ARG Release 2 by sections 205(a), 223 (d)(5)(A), 1614(a)(3)(H)(i), 163(d)(1) and 1631 (3)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility for benefits and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in ARG. In some cases, your information may also be reviewed by Administrative Law Judges and by Health Care Policy and Financing (HCPF) personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. The information we obtain with this form will only be used for the purpose of determining eligibility for Medicaid. The only two instances where your information will be released will be:

- To enable a third party (e.g. consulting physicians) or other government agency to assist ARG to determine eligibility to for Medicaid.
- 2. To provide necessary medical information for the purpose of consulting examinations. Other than the above limited circumstance, ARG will not redisclose any medical information without proper prior written consent information (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Agencies may use matching programs only to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from ARG or HCPF.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the <u>Paperwork Reduction Act of 1995</u>. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. SEND THE COMPLETED FORM TO: Arbor E & T, Action Review Group, PO Box 340, Olyphant, PA 18447. You may FAX it to ARG at 1-877-672-2077. You may call ARG at 1-877-265-1864. Email: actionreviewgroupmrt@arboret.com.

This form must be included:

• On the other side of the signed release

or

• must be attached to the release.

Disability Application Submission

Once the application has been completed, either the

Eligibility Site or worker must SEND THE

COMPLETE APPLICATION AND RELEASE FORMS TO:

Arbor E&T, Action Review Group,

P.O. Box 340

Olyphant, PA 18447

OR

Fax to 877-672-2077

Additional contact information:

Phone: 877-265-1864

Email: actionreviewgroup@arboret.com



Reminders for the Applicant

- Include a signed release form for every medical provider and three (3) additional forms for any new or discovered medical sources after the date of application
- All fields are required. Failure to do so will either result in a delay of processing or the application being sent back as an incomplete form
- Applicant must contact the Eligibility Site if there are changes to the applicant's:
 - Address
 - Phone number
 - Medical history (see new doctors, hospitalized)

Questions?





Contact Information

- Medicaid Eligibility Inbox
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